PROTOCOL CODE: MYBLDPRE

Patient RevAid ID:_____

DOCTOR'S ORDERS

Ht _____**cm** **Wt** _____**kg** **BSA**_____**m²**

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:_____

Risk Category: ☐ **Female of Childbearing Potential** (**FCBP**) Rx valid for 7 days

Risk Category: ☐ **Male or Female of non-Childbearing Potential (NCBP)**

☐ Delay treatment _____ week(s)

☐ **CBC & Diff, platelets** day of treatment

Proceed with treatment for entire cycle as written, if within 96 hours of Day 1: **ANC greater than or equal to 1.0 x 10^9/L, platelets greater than or equal to 50 x 10^9/L and eGFR or creatinine clearance as per protocol**

Dose modification for: ☐ **Hematology** ☐ **Renal Function** ☐ **Other Toxicity**

Proceed with treatment based on blood work from_____

LENALIDOMIDE

One cycle = 28 days

☐ **lenalidomide* ____mg** PO daily, in the evening, on days 1 to 21 and off for 7 days

☐ **lenalidomide* _____ mg** PO_____

(*available as 25 mg, 20 mg, 15 mg, 10 mg, 5 mg, 2.5 mg capsules)

***Note: Use one capsule strength for the total dose; there are cost implications as costing is per capsule and not weight based**

☐ FCBP dispense 21 capsules (1 cycle)

☐ For Male and Female NCBP:

MITTE:_____ capsules or _____ cycles . Maximum 63 capsules (3 cycles).

Pharmacy to dispense one cycle at a time, maximum 3 cycles if needed.

STEROID (select one)*

☐ **dexamethasone** ☐ **40 mg** or ☐ **20 mg** PO once weekly in the morning on Days _____ *(write in)* of each cycle

☐ **dexamethasone** _____ **mg** PO once weekly in the morning on Days _____ *(write in)* of each cycle

☐ **predniSONE** _____ **mg** PO once weekly in the morning on Days _____ *(write in)* of each cycle

☐ **No Steroid**

***Refer to Protocol for suggested dosing options**

Physician to ensure DVT prophylaxis in place: ☐ ASA, ☐ Warfarin, ☐ low molecular weight heparin, ☐ direct oral anticoagulant or ☐ none (select one)

Pharmacy Use for Lenalidomide dispensing:

Part Fill # 1

RevAid confirmation number:

_____

Lenalidomide lot number:

_____

Pharmacist counsel (initial):

_____

Part Fill # 2

RevAid confirmation number:

_____

Lenalidomide lot number:

_____

Pharmacist counsel (initial):

_____

Part Fill # 3

RevAid confirmation number:

_____

Lenalidomide lot number:

_____

Pharmacist counsel (initial):

_____

Special Instructions

DOCTOR'S SIGNATURE:

Physician RevAid ID:

SIGNATURE:

UC:

DATE:

TREATMENT:

- A referral to the Leukemia/BMT Program of BC must be made at the start of the first cycle or shortly after for planning purposes.
- Per physician's clinical judgement, physician to ensure prophylaxis with valACYclovir 500 mg PO daily

CYCLE # _____ (Cycles 1 to 6)

bortezomib ☐**1.5 mg/m²** or ☐**1.3 mg/m²** or ☐**1 mg/m²** or ☐ **0.7 mg/m²** or ☐ **0.5 mg/m²** (select one) x BSA =_____ mg subcutaneous injection on Days 1, 8, 15, and 22

RETURN APPOINTMENT ORDERS

For Cycles 1 to 6, book chemo on Days 1, 8, 15, and 22

☐ Return in four weeks for Doctor and Cycle _____

☐ Last cycle. Return in _____week(s)

CBC & Diff, platelets, creatinine, urea, sodium, potassium, total bilirubin, ALT, alkaline phosphatase, calcium, albumin, LDH, random glucose, serum protein electrophoresis *and* serum free light chain levels every 4 weeks

TSH every three months (i.e. prior to cycles 4, 7, 10, 13, 16 etc)

☐ **Urine protein electrophoresis** every 4 weeks

☐ **Beta-2 microglobulin** every 4 weeks

☐ **Immunoglobulin panel (IgA, IgG, IgM)** every 4 weeks

☐ **CBC & Diff, platelets** Days 8, 15, 22

☐ **Creatinine, sodium, potassium** Days 8, 15, 22

☐ **Total bilirubin, ALT, alkaline phosphatase** Days 8, 15, 22

☐ **Random glucose** Days 8, 15, 22

☐ **Calcium, albumin** Days 8, 15, 22

☐ **Quantitative beta-hCG blood test for FCBP** 7-14 days and 24 h prior to cycle 1 and every week for 4 weeks during cycle 1

☐ **Quantitative beta-hCG blood test for FCBP,** every 4 weeks, less than or equal to 7 days prior to the next cycle

☐ **Other tests:**

☐ **Consults:**

☐ **See general orders sheet for additional requests**

DOCTOR'S SIGNATURE:

SIGNATURE:

UC: